1977-08-12

P/S/R/O update: August 12, 1977 no. 35

August 12/77
Number 35

P/S/R/O Update

Boston University Medical Center

The Medical Cost/Quality Newsletter

Office of PSROs report gives breakdown by topic of 1976 medical care evaluation studies

PSRO program reports for the last half of 1976 show that the list of topics undertaken for medical care evaluation studies during 1976 by conditional PSROs was led by acute myocardial infarction, pneumonia, cholecystectomy and appendectomy, accounting for 15 percent of the total.

FIRST QUARTERLY REPORT

The data are part of the quarterly PSRO Management Information System reports prepared by the Bureau of Quality Assurance (now the Office of PSROs). The first report covers data from the third quarter of calendar 1976. These reports will be issued routinely by the PSRO program from now on.

The next four most popular topics comprise 10 percent of the total; they are listed below with the others that together account for 45 percent of all MCE topics done by PSROs in 1976.

In a summary of the reports presented to the National PSR Council meeting July 18-19, the first 100 conditional PSROs were shown to have had 1,546 MCEs in prog-

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INSIDE STORIES

Saloom court action said to delay naming of National Council members

Invitations to three physicians to take seats on the National PSR Council have been held up in the office of the DHEW secretary, for reasons that may be related to the court suit filed against the secretary by Council member Raymond J. Saloom, D.O., seeking to retain the seat the secretary ordered him to vacate July 1 (PSRO Update, July 1977).

NAMES DISCLAIMED

The names of three physicians reportedly chosen by Sec. Joseph A. Califano, Jr., were made known at the end of last month among people knowledgeable of PSRO activities, and the names of two of them appeared in print. However, word from the secretary's office the second week of August indicated that these three physicians may not be the ones selected, and that the invitations will not be sent out for "at least several weeks."

Califano's attorneys have recommended to the Justice Department that the temporary injunction granted by a federal judge be appealed. The temporary injunction allows Saloom to retain his seat on the National PSR Council pending a hearing Sept. 7 on a permanent injunction.

This is the first time that a member of a national advisory committee has challenged his removal by a DHEW secretary. Presumably, if any of the three

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PSRO Update, which covers the federally mandated Professional Standards Review Organization program and the broader field of medical cost and quality, is published monthly by Boston University Medical Center Address editorial inquiries to **PSRO Update,** 720 Harrison Avenue, Suite 300, Boston, MA 02118. Telephone (617) 247-5606. Address subscription inquiries to **PSRO Update,** 306 Dartmouth Street, Boston, MA 02116, Telephone (617) 267-7100. Executive Editor/Donald R. Giller. Managing Editor/Owen J. McNamara. News Editor/Barbara Mackey. Contributing Editors/Lorraine Loviglio, John Blum. Correspondents throughout the nation. Staff assistants/Rose Razzino, Diane Leclaire.

ANALYSIS

Reporting requirement stirs PSROs' opposition; they fear identifying individuals

The Office of PSROs has proposed a policy that would require each PSRO to send in Medicare provider numbers with its routine reports to DHEW. These numbers, attached to institutional profiles, would ascertain the identity of the institutions involved in PSRO review.

From the standpoint of many PSROs, this identification of institutions will lead inexorably to identification of both individual practitioners in small hospitals and one-of-a-kind specialists in hospitals large and small.

7-1 NEGATIVE REACTION

In April, the Bureau of Quality Assurance (now the Office of PSROs) issued a draft transmittal announcing the proposed changeover to the Medicare provider number. Currently, PSROs submit a PSRO-specific three-digit number that conceals the identity of the institution but allows the government to examine the characteristics of each institution. The reaction to the proposal from the field, according to William Cresswell, of the division of data planning and analysis, was seven-to-one against the move. He reported the status of the plan to the National Council July 19.

At the meeting, Council members inveighed against the proposed new policy while Cresswell and OPSRO Acting Administrator Michael J. Goran, M.D., presented arguments in favor of it.

In that debate, which mirrors the larger, national debate, PSRO physicians seemed to be telling the government that, just because PSRO data will be of exceptionally high quality, it doesn't mean that the data ought to be used by whatever agency asks for them, nor especially, that the data ought to be aggregated without first protecting identities of patients and practitioners.

OPSRO officials, for their part, appeared to be saying that PSROs failed somehow to see the implications of continued resistance to supplying that Medicare provider number. One of those implications is that the government will not tolerate duplicative systems of data collection and recording, and that if the PSROs do not take the lead role, other agencies will, and PSROs may be left to obtain their data from another organization.

ALTERNATIVE PROPOSALS DUE

For the moment, the issue is at impasse. At the Sept. 12-13 National PSR Council meeting, however, OPSRO plans to present alternative suggestions for protecting individual identity while continuing to mandate collection of the Medicare provider number.

The point that concerns many physicians is that the identification of individual hospitals could lead to the implicit identification of individual practitioners who admit and treat patients in the hospitals. No one seems to disagree that this is a possibility; but there is no agreement on how many hospitals, and, in turn, how many practitioners, this applies to.

In addition, some physicians see the Medicare provider number as providing a link to patients' identities. Robert T. Kelly, M.D., a member of the National PSR Council, spoke of this fear at the July meeting. "If you know the practitioner and the procedure, you can quite easily narrow down the list of patients to maybe 10 or 15. For example, a hospital that has 10 cataract procedures in a month, where there is only one opthalmologist, you know the practitioner for certain, and you've narrowed down to 10 patients. You may not be able to identify the specific patient, but you get down to small numbers," Kelly said.

AN ADMITTED CONCERN

Acknowledging these criticisms of the DHEW policy, Cresswell said later in an interview, "The potential for implicit identification of individual physicians is a major problem, and we've got to look at ways of addressing this concern and still go where we want to go. We're not going to just fly in the face of everyone's resistance."

It's clear that OPSRO regards the Medicare provider number as essential to its data analysis. There's no hint of the government's backing away from that policy.

Currently, PSROs collect the number but do not transmit it to Washington with their reports. The requirement that PSROs collect the Medicare provider number took effect in 1974, promulgated by then Sec. Caspar Weinberger.

The Medicare provider number is the most universal hospital identifier in use today. It is part of the Uniform Hospital Discharge Data Set, a portion of which is collected by Medicare and some state Medi-

caid agencies. PSROs collect what is called the PHDDS -- the UHDDS plus the PSRO elements for specific PSRO review data.

In addition, the National Center for Health Statistics and the Cooperative Health Statistics System collect the UHDDS. This Uniform Hospital Discharge Data Set contains the 14 pieces of information deemed essential by the U.S. National Committee on Vital and Health Statistics for standardizing multipurpose data collecting. It includes patient identification, date of birth, sex, race, admission date and hour, diagnoses, procedures, attending physician, operating physician, discharge date, source of principal payment and disposition of patient.

The Medicare provider numbers, and therefore, the identities, of hospitals are available in the data of a number of collectors, but the data are scattered. The PSRO officials want to pull them together to prepare reports and to aggregate meaningful information for health systems agencies, state rate-setting commissions and other legitimate users.

WHY IT IS NEEDED

Why does the PSRO program need to have that Medicare provider number? Cresswell asked the Council, rhetorically. "Our basic premise is to facilitate the sharing of data on the local, state and national levels for legitimate purposes, such as for epidemiological studies," he said. "But, it is also needed for the PSRO monitoring at state and federal levels," something required of Medicare and Medicaid agencies. To do that monitoring and to undertake those studies, he indicated, the PSRO data must be linked with other data.

"What we can't do now is link with other data bases. That's hurting us because we're getting a lot of scrutiny from Congress and elsewhere, from those seeking to know the impact of the program. It's still too early to tell what the impact is because our data are just beginning to come in," Cresswell said.

It is clearly central to OPSRO's plans that PSROs assume the pivotal role of collecting and then disbursing clinical data on utilization and quality of medical care in the United States, for the overriding reason that PSROs will be producing the highest quality data yet available. And, by sharing the data with others for epidemiological studies, OPSRO officials reason, the PSRO program has a better shot at raising the quality of care because decisions will have been based on high quality data.

AMA's VIEWPOINT

However, the idea of sharing PSRO data falls short of receiving universal endorsement. The American Medical Association, commenting on specifications for regulations on confidentiality, told DHEW that PSROs "do not exist as a library of health care information for either the government or the general public." The statement elaborated, saying, "PSROs have been given a specific assignment to review federally funded medical care as to its quality, appropriateness and necessity based upon norms of practice for the region (in which each) serves. Data collected or generated by a PSRO are in furtherance of that assignment, and PSROs should not be regarded as an easy source of information by government agents, researchers or the merely curious."

This is not a unanimous opinion on the part of physicians, for several members of the National PSR Council, including Ruth M. Covell, M.D., indicated support for "a data linkage at the federal level." She also made the point that "if there isn't some sharing of these data, other data systems will develop, such as through HSAs, which would leave the PSROs trying to get their data from somewhere else instead of through their own system."

DATA QUALITY IS KEY

The arguments from OPSRO for sharing data keep coming back to the quality of the data. Cresswell says, "We feel that it may be the most consistently accurate data of its type that has existed to date. It's not billing information, it's clinical information. It encompasses 100 percent of the Medicare and Medicaid patient populations, not the 20 percent sample that Medicare collects, and we're talking about all diagnoses, not just the primary diagnosis and procedure that Medicare collects.

"It's not collected just for statistical purposes, it's collected for PSRO review purposes, for focusing review. You need accurate data to do that," Cresswell said.

September's National Council meeting should further elucidate the whole question of protecting individual identity as against DHEW's need for collecting the Medicare provider number from PSROs. It remains to be seen whether there will be a solution to the conflict between PSROs and the federal officials. ■

Saloom court action said to delay naming of National Council members

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other Council members whose terms were ended June 30 by Califano chose to sue, that step is still open to them. It may be this possibility that is holding up the invitations to new members. ■

AAPSRO, AAFMC meet this month in Missouri

The American Association of PSROs and the American Association of Foundations for Medical Care will hold their joint annual meeting August 13-17 at the Tan-Tar-A Resort, Osage Beach, Missouri. In addition to meetings for delegates of the two organizations, there will be sessions convened for subgroups of executive directors and review coordinators. The AAPSRO has headquarters at 445 W. Acacia St., P.O. Box 230, Stockton, CA 95201. ■

Health technology office within DHEW proposed in health policy monograph

A proposal to establish a new office within DHEW to manage health technology policy is one of the recommendations made by the Boston University Health Policy Institute in its latest policy monograph, published in June, on quality of care in health. The proposed office would be headed by a deputy assistant secretary for health technology policy. The agency would be charged with collecting and analyzing research findings and with developing guidelines for research to be carried out by other agencies within DHEW.

The monograph, "Health Care Technology: Can We Decide What to Buy?" grew out of a conference held in November 1976 and supported by a grant from the Robert Wood Johnson Foundation. The authors are Cynthia H. Taft, M.A., Paul M. Gertman, M.D., and Richard H. Egdahl, M.D., Ph.D. Copies of the 71-page book are available for $3 each from the Boston University Health Policy Institute, 53 Bay State Road, Boston, Mass. 02215. ■

National PSR Council keeps to September schedule

The next National PSR Council meeting will be held as originally scheduled, the Jewish religious holiday notwithstanding, on Sept. 12-13 beginning at 10 a.m. in the auditorium of HEW North, Washington, D.C. ■

Office of PSROs report gives breakdown by topic of 1976 medical care evaluation studies

(Continued from pg. 1)

ress during the last quarter of 1976, and to have completed 2,638 initial audits during the calendar year. In contrast to the large number of MCEs under way, there were only 59 reaudits completed by the end of 1976.

Deficiencies, which were not further defined in the presentation, were found by 75 percent of the MCEs.

COMPARES TIME SPENT

Other figures revealed that the median number of hours spent by physicians on MCE studies was 13 and that the comparable time for all personnel was 50 hours per audit.

The report also showed that for the period of July to December, the costs per hospital discharge of a PSRO's doing concurrent review varied by nearly $10. The group of ten PSROs that had primarily non-delegated hospitals (that is, PSROs that did most of the reviewing with their own personnel) came in with a low cost per discharge of $5.75, a median of $10.97 and a high of $15.29.

Cost of review figures were not given for PSROs that had primarily delegated hospitals.

MOST FREQUENT MCE STUDY TOPICS FOR THE CALENDAR YEAR 1976

1.	Acute Myocardial Infarction	15%	45%
2.	Pneumonia		
3.	Cholecystectomy		
4.	Appendectomy		
5.	Hysterectomies	10%	
6.	C-Sections		
7.	Diabetes Mellitus		
8.	Medicinal Agents		
9.	T & As	9%	
10.	Hip Fractures		
11.	Gastroenteritis		
12.	CVAs		
13.	Hypertension		
14.	Asthma	11%	
15.	T.U.R.		
16.	Cancer of Colon		
17.	Pulmonary Embolism		
18.	Peptic & Duodenal Ulcer		
19.	Inguinal Hernia		
20.	Urinary Tract Infection		
21.	Normal Delivery		
22.	Cataract Extraction		

Decision on PSRO tax status carries language that adds insult to injury, officials told

The Internal Revenue Service ruled earlier this summer on the two-year old question of which form of tax-exempt status PSROs should have (see PSRO Update, June 1977). The decision provoked reactions of annoyance from some PSROs, but this dissent was mild compared to the furor that ensued over the language the IRS used to back its decision.

PSROs have been placed, along with the American Medical Association, the American Dental Association, state and federal bar associations, chambers of commerce and other business and professional groups in the 501(c)(6) nonprofit category for organizations that promote the common business or professional interests of their members. PSROs are not charitable organizations, the IRS says, and thus are not eligible for the 501(c)(3) designation some had sought.

However, the IRS reasoned that (c)(6) was appropriate because PSROs "minimize public criticism by assuring that physicians and other health care practitioners do not improperly utilize health care resources and facilities."

TAKEN UP AT COUNCIL

The 'minimize public criticism' phrase enraged some National PSR Council members, who argued for 30 minutes at last month's Council meeting with three IRS officials. Robert Kelly, M.D., told the three, "I don't question the ruling but I do question the words in which you couch your reasoning -- this wording has the potential for destroying the PSRO program."

The Council members made their point: physicians, who feel they are maintaining the integrity of their profession by cooperating with the PSRO program, don't want to be told they are acting in their own interest and are muting public criticism by their monitoring of their peers; physicians may, in fact, be stirring up public criticism by their peer review actions.

The Council asked the DHEW staff to try to get the IRS to rewrite their rationale for 501(c)(6) status.■

Richmond takes oath as asst. secretary for health

Julius B. Richmond, M.D., was sworn in last month as the assistant secretary for health six months after that office was vacated in the change of administrations.

Richmond had been chairman of the department of preventive and social medicine at Harvard Medical School and psychiatrist-in-chief at Children's Hospital Medical Center, Boston. He comes to his post with federal administrative experience as the first director of both the national Head Start program and health affairs of the Office of Economic Opportunity in the mid-1960s.

The new assistant secretary was also appointed to be the surgeon general, a position that has been vacant for about four years, and as such he serves as the commanding officer of the Public Health Service commissioned corps.■

PSROs getting involved in Indian Health Service institutions in 8 states

PSRO review will be expanded to hospitals, health centers and health stations of the Indian Health Service located in eight western states.

Under a 1976 law, Indian Health Service institutions became eligible for reimbursement for services rendered to Medicare and Medicaid beneficiaries and recipients.

PSROs TOLD 'GET INVOLVED'

In Transmittal 49 from DHEW, dated June 3, 1977, PSROs in areas of Indian Health Service institutions are directed to "become involved" with these institutions.

For those PSROs that have begun review, "the PSRO will need to begin to phase in review in certified IHS hospitals immediately." Planning PSROs are asked to include IHS hospitals in their proposed review plans.

As to long-term care institutions, a PSRO "can offer assistance to skilled nursing facilities and intermediate care facilities regarding utilization review systems, but should not begin to phase in such institutions under PSRO review, unless a PSRO has an approved long-term care review plan."■

AHA sessions in Atlanta to weigh key PSRO issues

The American Hospital Association will hold its annual meeting Aug. 29-Sept. 1 in Atlanta, Ga. PSRO-related sessions will cover such topics as: confidentiality of medical records; nonphysician peer review; policies and progress; HSA-PSRO relationships; productivity indices versus quality care; quality assurance initiatives; federal reimbursement, legislation and regulation; and special sessions on the "Washington Scene" and hospital controls.■

New York State Support Center offers videotapes on UR

The New York PSRO Statewide Support Center has prepared a five-part instructional videotape series for health professionals entitled "Health Resources Allocation through Utilization Review in the Acute Care Hospital."

The videotapes are available on loan for a two-week period for a refundable deposit fee of $250. The address is: 420 Lakeville Road, Lake Success, N.Y. 11040.■

Hospital regulation report urges continued development and expansion of PSROs

While congressional pressure mounts for PSROs to demonstrate their impact, a recently published report on hospital regulation urges that PSROs "be allowed additional time to develop their potential."

"Hospital Regulation: Report of the Special Committee on the Regulatory Process," by a group appointed by the American Hospital Association, urges that PSROs continue to be the focus of utilization regulation and that PSRO review be expanded to all hospital patients, and ultimately, to all patients wherever they receive health care.

33 RECOMMENDATIONS

The report, which contains 33 recommendations covering regulation of health planning, facilities and payment as well as utilization, does not portray AHA policy, but opens discussion intended to lead to official AHA recommendations next year.

The other PSRO recommendations are, briefly:

--hospitals that are large enough should develop the necessary qualifications and become delegated by their PSROs to do review;

--the Joint Commission on Accreditation of Hospitals should monitor the relationship between a hospital and its PSRO to identify deficiencies and recommend corrections;

--hospital trustees and management should find ways to ensure the accountability of their medical staffs, including their own participation on credentials committees;

--PSROs should be required, by statutory amendment, to report at least annually to the public, providers and payers in their areas describing goals, activities, achievements and impact on services;

--also by amendment, PSROs should be required to coordinate with each other and with other types of regulatory bodies in order to become more accountable to each other and the public;

--PSRO data, as long as they protect the identities of individual patients and physicians, should be shared with legitimate users;

--to improve standards of care, PSROs should at first develop criteria for the evaluation of medical care based on recorded data and peer judgments, but gradually move to "scientific determinations of what is medically effective and efficient."

The report is available for $5 from: Order Control Department, American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611.■

Paris: City of light, beauty, romance--and a pilot PSRO program

If imitation were the sole measure of success, the PSRO program might well be dubbed "successful" right now, sans Congressional evaluation: A pilot PSRO program will be started in the hospitals of Paris.

William B. Munier, M.D., director of the Office of Quality Standards, reported to the National PSR Council in July that "somewhat to my surprise," the French health planners he was invited to meet with in May 1976 have decided to embark on a Paris PSRO "modelled after the one we have in this country." ■

N.Y. PSRO-state impasse holds; possible solution rests with congressional action

NEW YORK, N.Y.--While both sides report no new move to break the existing impasse between the PSROs in New York State and the state health department, a possible solution may lie in congressional action.

HOSPITALS IN MIDDLE

Meanwhile, each side maintained its position in separate messages. In the middle of the confrontation are the hospitals with Medicaid patients, being tugged and pulled, in a sense, as the PSROs and the state health department overlap in hospital review functions.

The latest messages involved an internal memorandum in the state health department, and a message from several New York PSROs to delegated hospitals on the question of confidential records.

The internal memorandum within the state health department came from William Liddle, a health department official, who noted that DHEW had urged that the state

"remove onsite staff to allow PSROs full responsibility for inpatient review decisions." In the memorandum, Liddle also declared that the DHEW policy statement is "the same position DHEW has taken since the inception of the onsite program, and New York State has been aware of it all along."

Liddle continued: "I can assure you that New York State is not contemplating any change in its onsite or non-onsite program implementations, requirements or administration. All onsite staff are to continue functioning under the same guidelines they have had to date, and onsite, non-onsite orders should continue to be scheduled and conducted."

CAUTION ON DISCLOSURE

Statements from PSRO officials emphasize that Section 1166 of Public Law 92-603 prohibits the unauthorized disclosure of PSRO data and/or information. One such statement, sent to hospital directors of delegated hospitals, by the Kings County Health Care Review Organization, which has 29 delegated hospitals, noted that "Section 1166 is presently being subjected to legal interpretation, but pending issuance of a final transmittal by the Department of Health, Education, and Welfare, we have been advised that disclosure of any data collected as part of the PSRO program could be a violation of Section 1166 with the potential for fine and/or imprisonment.

"I therefore wish to caution you that the PSRO data abstracts and utilization review forms used in the review process at your hospital may not be disclosed to any agency, including the New York State Health and Social Service Departments. We suggest that requests for PSRO concurrent review forms and data abstracts be referred to our office." The message was signed by John Q. Podesta, executive director of the Kings County PSRO.

NO STATE RESPONSE

F. Lawrence Clare, M.D., acting director of the Division of Professional Standards Review Organization, Region II, told PSRO Update that he had heard of no response by the state to a letter of Robert Derzon, head of the Health Care Financing Administration of DHEW, demanding that the state comply with federal regulations. (Derzon had given the state 30 days, until about August 9, to comply.)

"The only thing that's happening is that we found a case in a Manhattan hospital where the PSRO had been certifying against some claims, and the state paid them anyway," Clare said. "It's a smaller number, but the significance, I think, is pretty great. I sent a letter on this to the state Department of Social Services, but but there was no response. I did not ask for an answer."

Clare said that H.R.3, a bill aimed originally at fraud and abuse in Medicare and Medicaid, soon became extended to some technical aspects affecting PSROs that supposedly would make administration easier. "When the PSRO and state matter became joined, several states and several PSROs (not including New York State) went before Congress, and congressional committies heard both sides," he said. "The big issue was PSROs' authority for medical necessity for Medicaid patients. One result of this was reaffirmation of the PSROs' right to rule on medical necessity of Medicaid patients. The states lobbied very hard against this provision, as did the PSROs for their viewpoint."

ACCOMMODATION SOUGHT

The under secretary of DHEW then decided he would try to arrange an accommodation to satisfy both the states and the PSROs, Clare continued, and held meetings with both sides. After lengthy discussions, he said, they hammered out "elements of this kind of accommodation."

Derzon had offered to apply provisions of H.R.3, even before passage. "Specifically," he wrote in his letter to the New York State Department of Social Services, "if the state of New York is willing to come into compliance and conformity with PSRO requirements, we are willing to apply the state/PSRO consensus embodied in the pending H.R.3 legislation." He added that the bill provides "the state with a strong involvement in the PSRO program and requires PSROs to be responsive to justified concerns of the state."

Included in the provisions is one permitting the governor of the state to "comment when a PSRO is being evaluated for conditional designation, for expansion into the areas of long term care and ambulatory review, and for fully operational status, with a further opportunity to comment if his views differ from those of the secretary of DHEW." Another provision of H.R.3 is a "requirement for a memorandum of understanding between the state and PSRO, unless the secretary [of DHEW] waives this requirement because the state does not desire to enter into an MOU or refuses to negotiate in good faith or in a

timely manner with the PSRO."

A third provision gives the state the right to "request the PSRO to include in the MOU a specification of review goals or methods for the performance of ... review." ■

Goran says by Sept. 30 only 5 areas in nation will be without PSROs

For physicians who had been apprehensive about the possibility of nonphysician PSROs (alternative PSROs) being funded after next Jan. 1, DHEW has some reassurance that if there are any such groups, the number will be small.

JAN. 1 IS DEADLINE

Jan. 1 is the statutory deadline for physician groups to form PSROs. After that date, a group of nonphysicians could qualify for a PSRO contract.

Michael J. Goran, M.D., acting administrator of the Office of PSROs (formerly the Bureau of Quality Assurance), reported to the National PSR Council last month that by the end of this fiscal year, Sept. 30, there will be five or fewer areas without PSROs: two in California and three in Florida.

Also by Sept. 30, Goran said, his office expects there will be 120 or more conditional PSROs and 70 planning organizations. ■

Califano would support PSRO dental membership

The dental profession has received the support of the DHEW secretary in its bid to have PSRO membership opened to dentists.

Sec. Joseph A. Califano, Jr., has indicated in a letter to the chairman of the National PSR Council that he agrees with the decision of that body to endorse an amendment to the PSRO law to allow dentists to become PSRO members. The Council has recommended that eligibility for membership be broadened to include all members of a medical staff who have independent hospital admitting privileges.

The draft of an amendment to effect this change in Congress is being written by DHEW staff, according to a report to the National PSR Council July 18 from William B. Munier, M.D., director of the Office of Quality Standards. ■

GAO report views HCFA as improvement, with some problems

A Government Accounting Office report has found some continued duplication among the new Health Care Financing Administration and other elements of DHEW, but overall, it sees HCFA as offering the potential for better management of the programs that have now been gathered under the single administrative unit. (See PSRO Update, July 1977.)

The report, requested by Sen. Herman Talmadge (D-Ga.), chairman of the Senate Finance Committee subcommittee on health, concludes that "just the fact that Medicare, Medicaid and quality and standards have been placed primarily under the direction of one agency head should result in improved management of the programs through better coordination of efforts and exchange of information." Talmadge received the report at a July 21 subcommittee hearing at which Gregory J. Ahart, director of the Human Resources Division of the GAO, presented the findings of the month-long study.

REPORT OF FINDINGS

The GAO found that:

--the number of "supergrade" positions had been reduced, partly in response to Talmadge's earlier criticism, to about half of the number initially requested, or 22 positions as of July 11;

--officials in DHEW viewed the continued split in management of health financing programs between HCFA and the Public Health Service as unresolved by the reorganization, but that many felt "informal arrangements and the goodwill of the people involved would overcome these difficulties;"

--there were some specific segments of HCFA, mostly in planning and evaluation, that duplicated other segments and could be eliminated; and

--the parts of HCFA concerned with program integrity and administration of standards and provider certification, which offered the main opportunity for consolidation, have actually been merged.

Talmadge requested that the GAO continue to monitor the work of HCFA and make monthly reports to his committee for the next year. ■